**NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES**
**STATE/COMMUNITY MATCHING**
**LOAN REPAYMENT PROGRAM**
**REQUEST FOR REIMBURSEMENT**

ND Department of Health
Division of Health Facilities
SFN 51139 (8-2001)

Dept. Use Only

File Number:

Contract Number:

Telephone: 701-328-2352

| | |
|---|---|
| Name of Health Professional | |
| Name of Community | |
| I am requesting reimbursement from the Health Professional Loan Repayment Program per Chapter 43-12.2 of the North Dakota Century Code. I have completed the required three (3) months of full-time service to the community and I am therefore eligible to receive the first year payment. | |
| Date the three (3) months of full-time practice completed: | First Year Payment:<br>$ |
| Please send my payments to:<br>Address City State Zip Code | |

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Signature of Health Professional Date